Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

HOUSTON TX 77030

Requestor Name and Address

FONDREN ORTHOPEDIC GROUP
7401 S. MAIN

Respondent Name
NORGUARD INSURANCE CO

Carrier's Austin Representative Box
Number 19

MFDR Tracking Number
M4-12-3501-01

MFDR Date Received
August 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Request for Reconsideration letter dated May 14, 2012:
"…We respectfully disagree with this payment for the procedure 23472-22 [sic]…Modifier -22 was used to symbolize the unusual circumstances therefore an additional allowance should be considered. If you would read the operative report under PROCEDURE PEROFRMED [sic]: it clearly states the complexity of this procedure. When a modifier -22 is utilized we are expecting an additional 25% of the allowed amount because the procedure was more complicate [sic] then [sic] expected…"

Amount in Dispute: $386.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The provider submitted a request for medical dispute resolution on August 1, 2012 for healthcare services provided on March 28, 2012 and is seeking reimbursement in the amount of $386.95.00 [sic]. The carrier relies upon its review and reduction of the provider's bill as reflected in its EOBs. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made…"

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, 2012	25608-22	$386.95	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for

resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.203 sets forth the guidelines for professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1 amended to be effective March 1, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. The services in dispute were reduced by the respondent with the following reason codes:

   Explanations of benefits
   - W1 – workers compensation state fee schedule

Issues

1. What is the applicable fee guideline for the service in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The service in dispute is a professional service performed by a physician. 28 Texas Administrative Code §134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications…" Furthermore, 28 Texas Administrative Code §134.203(f) states that "For products and services for which no relative value unit or payment has been assigned by Medicare…reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)." Review of the medical bill finds that the service in dispute was billed under code 25608-22. The Medicare Claim Processing Manual, Chapter 12, states that surgeries billed with a -22 modifier are priced by individual consideration. That is, Medicare does not assign a payment for 25608 when the -22 modifier is appended. For that reason, the division concludes that reimbursement for the service in dispute is provided by §134.203(f).

2. In support of its request for additional reimbursement, the requestor states "Modifier -22 was used to symbolize the unusual circumstances therefore an additional allowance should be considered…we are expecting an additional 25% of the allowed amount because the procedure was more complicate [sic] then [sic] expected." 28 Texas Administrative Code §134.1(f) states, "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
   - The requestor did not submit documentation to support how payment of an additional 25% or $386.95 would result in a fair and reasonable reimbursement amount.
   - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work.
   - The requestor did not discuss or support that similar procedures provided in similar circumstances received similar reimbursement.
   - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code 413.011(d).

   Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that the additional payment amount of $386.95 would be a fair and reasonable rate of reimbursement for the service in dispute. As a result, additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services involved in this dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.